Annual Review
1984

Office of the Chief Medical Examiner

Alberta
ATTORNEY GENERAL

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Introduction

The Office of the Chief Medical Examiner in Alberta is responsible under the Fatality Inquiries Act and the Vital Statistics Act for the investigation and certification of all deaths by violence, as well as unexpected, unexplained or unattended deaths. Certain hospital and institutional cases, notably those of persons dying within ten days of surgery or anaesthesia, are investigated, as are deaths of persons held involuntarily. As well, the Medical Examiner's Office is responsible for providing authority for cremation or anatomical dissection in Alberta and shipment of bodies from Alberta.

The area of jurisdiction is the province of Alberta, which has a population of approximately 2.3 million. In addition, the Medical Examiner has jurisdiction over those who travel through the province.

The Medical Examiner System, under the direction of the Chief Medical Examiner, is managed from regional offices located in Calgary and Edmonton. The Chief Medical Examiner is based in Calgary; each regional office is under the direction of a Deputy Chief Medical Examiner. The Edmonton office administers the northern part of the province; the Calgary office administers the area south of a horizontal line between Jasper and Provost through Hobbema. Each office has a permanent staff of four medical investigators, six forensic autopsy technicians and three record technicians. Additional staff members include supervisors, administrators, photographers/radiographers, a research officer and assistant, and secretarial personnel. During the period in review, recruitment was in progress to fill one position for a pathologist.

A medical investigator and medical examiner are on duty evenings and weekends for investigations and consultations. Autopsies and examinations are performed daily. A toxicology laboratory is included in the Edmonton Medical Examiner's facilities and is directed by a Ph.D. biochemist who has technologists on staff. Approximately 150 medical examiners and 25 pathologists are on a part-time, fee-for-service basis throughout the province.

The Year in Review

In 1984, 4,700 deaths were reported to the Medical Examiner. This represented approximately one-third of all deaths in Alberta during the year. In each case, the report developed by the Medical Examiner contained information on the cause, manner, and circumstances surrounding the death.

In the two central offices, 2,051 cases, representing 53.7% of the Medical Examiner cases, were investigated and certified by full-time medical examiners. The remainder of the cases were examined and certified by part-time medical examiners who were assisted by pathologists, city police, or the RCMP. Their continuing support and willingness to perform this valuable community service made it possible to maintain the high standards of the provincial Medical Examiner system.

In August of 1984, the Office of the Chief Medical Examiner began a tissue donation program in Edmonton. Next of kin were contacted shortly after death and asked to consent to donating the corneae of the deceased. Through the program, 16 pairs of eyes were made available to the corneal transplant surgeon at The University of Alberta. This represented a positive response from 45% of families approached. As a result of this success and of public acceptance, it was planned to expand the program to Calgary in 1985.

Caseload Statistics

TOTAL CASES

1. CERTIFIED CASES

Manner of Death	Cases	Aggregate Rate per 100,000 population
Natural	2,153	96.3
Accident	853	2.1
Suicide	423	18.1
Homicide	50	2.1
Unclassified	165	7.0
Undetermined	74	3.1
Acceded *	99	—
**2. OTHER CASES ** **	883	—
TOTAL	4,700	163.3

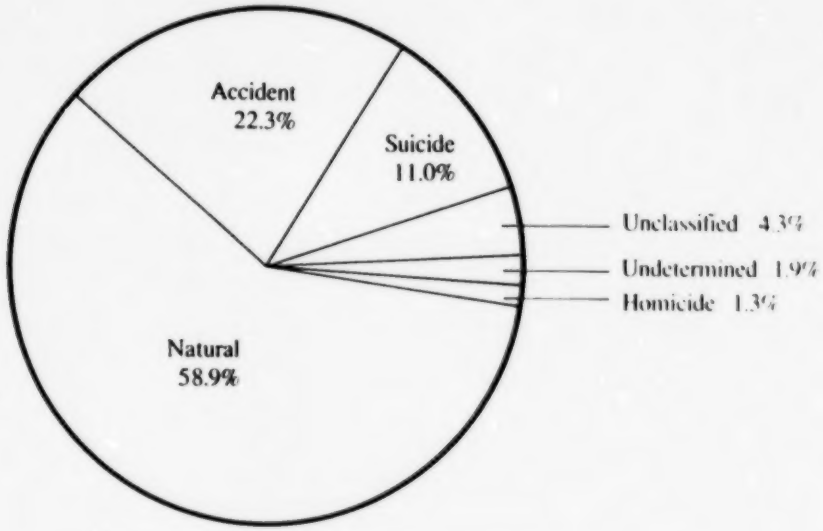
* Acceded - Cases investigated by the Medical Examiner after the fact, primarily reportable deaths inadvertently or improperly certified by attending physicians. These cases come to the attention of the Medical Examiner during the routine review of all death certificates issued in Alberta.

** Other Cases - Cases which are reported but do not require a full investigation. (See Refereed Cases)

REGIONAL DISTRIBUTION OF CERTIFIED CASES

	Calgary	South Rural	Edmonton	North Rural	TOTAL
Natural	506	487	859	400	2,252
Homicide	13	7	21	9	50
Suicide	82	83	135	123	423
Accident	121	256	160	316	853
Unclassified	18	9	90	48	165
Undetermined	8	33	21	12	74
TOTAL	748	875	1,286	908	3,817

MEDICAL EXAMINER CASES



CASELOAD REVIEW 1975 - 1984

	Calgary	South Rural	Edmonton	North Rural	TOTAL
1975	664	656	689	741	2,750
1976	669	572	602	764	2,607
1977	678	800	658	827	2,963
1978	783	796	902	911	3,392
1979	920	876	1,084	975	3,855
1980	1,011	957	1,142	983	4,093
1981	944	934	1,223	917	4,018
1982	973	838	1,325	884	4,020
1983	965	826	1,295	849	3,935
1984	748	875	1,286	980	3,817

REFEREED CASE REVIEW *

	1981	1982	1983	1984
Calgary	323	295	304	463
South Rural	70	45	104	158
Edmonton	124	98	225	201
North Rural	41	45	58	61
TOTAL	558	483	691	883

* Refereed Cases - Deaths reported to the Medical Examiner according to Section 15 of the Vital Statistics Act, deferred to the attending physician on the basis that the death was natural, that the physician was able to certify the medical cause of death with reasonable accuracy and received the consent of the Medical Examiner.

Types of Death Investigated and Certified

Homicides

	Male	Female	TOTAL
Calgary	13	—	13
Edmonton	14	7	21
North Rural	6	3	9
South Rural	3	4	7
TOTAL	36	14	50

AGE/METHOD

Method / Age:	0-9	15-19	20-29	30-39	40-49	50-59	over 60	TOTAL
Fight/ Brawl	—	—	1	1	—	1	—	3
Hanging/ Strangulation	3	—	—	—	1	1	1	6
Firearms	—	1	5	5	1	1	—	13
Stabbing/ Incised wound	—	—	6	5	1	4	—	16
Child Battery	4	—	—	—	—	—	—	4
Other	1	1	3	—	2	1	1	8
TOTAL	8	2	15	11	5	8	1	50

Suicides

AGE GROUP	MALE	FEMALE	TOTAL	RATE/100,000 POPULATION
10 - 14	5	1	6	3.4
15 - 19	24	7	31	16.0
20 - 24	48	12	60	24.2
25 - 29	36	11	47	17.7
30 - 34	37	13	50	23.0
35 - 39	26	8	34	19.3
40 - 44	28	12	40	30.5
45 - 49	17	8	25	22.9
50 - 54	28	11	39	38.0
55 - 59	20	8	28	30.8
60 - 64	18	6	24	30.3
65 - 69	9	2	11	18.3
over 70	22	6	28	23.6
TOTAL	318	105	423	18.1

REGION

Month of Death	Calgary	Edmonton	North Rural	South Rural	Total
January	9	14	8	9	40
February	2	14	10	10	36
March	6	12	7	2	27
April	10	8	14	5	37
May	9	15	5	6	35
June	6	7	16	10	39
July	5	9	7	10	31
August	6	15	9	5	35
September	6	9	13	6	34
October	8	6	7	8	29
November	9	14	15	7	45
December	5	12	12	5	34
Unknown	1	0	0	0	1
TOTAL	82	135	123	83	423

SUICIDES 1975 - 1984

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984
Calgary	78	84	88	90	83	103	94	109	106	82
South Rural	69	60	76	79	56	91	70	63	70	83
Edmonton	68	97	89	84	104	99	97	112	120	135
North Rural	72	78	97	81	82	107	103	97	124	123

SUICIDE RATES PER 100,000 POPULATION BY YEAR

Year	Estimated Population (000's)	Total Suicides	Rate/ 100,000	Year	Estimated Population (000's)	Total Suicides	Rate/ 100,000
1960	1,291.1	115	8.9	1972	1,675.3	212	12.6
1961	1,332.0	120	9.0	1973	1,680.5	222	13.1
1962	1,369.0	120	8.8	1974	1,722.4	281	16.3
1963	1,402.0	118	8.4	1975	1,811.8	287	15.8
1964	1,430.0	162	11.3	1976	1,885.2	319	16.9
1965	1,450.0	162	11.2	1977	1,965.8	350	17.9
1966	1,463.2	145	9.9	1978	2,028.8	334	16.5
1967	1,490.0	135	9.1	1979	2,109.6	325	15.4
1968	1,524.0	160	10.5	1980	2,205.1	400	18.1
1969	1,559.0	195	12.5	1981	2,293.5	364	15.9
1970	1,595.0	204	12.8	1982	2,347.7	381	16.2
1971	1,627.9	191	11.7	1983	2,361.0	420	17.8
				1984	2,300.0	423	18.1

METHOD

	Male	Female	TOTAL	PERCENTAGE OF TOTAL
Drug overdose/poison	46	37	83	20%
Carbon monoxide	54	23	77	18%
Hanging/strangulation	72	21	93	22%
Submersion	3	4	7	1%
Firearms	121	7	128	30%
Incised wounds	5	3	8	1%
Jumping	10	5	15	4%
Other	7	5	12	3%
TOTAL	318	105	423	100%

NATIONAL SUICIDE RATES* PER 100,000 POPULATION 1975 - 1984

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984
National Rate	12.4	12.8	14.3	14.8	14.1	14.0	14.0	13.9	15.1	13.7
NFLD	3.5	3.8	3.7	2.6	4.4	3.4	4.2	6.0	6.2	6.7
PEI	11.9	19.5	10.0	13.1	13.1	11.4	7.4	8.9	12.9	12.0
NS	10.4	10.4	11.3	12.5	12.6	11.5	10.9	12.2	12.1	9.9
NB	8.0	10.9	10.5	12.9	12.1	11.6	11.1	12.9	14.2	12.6
QUE	9.3	10.5	12.4	14.2	15.4	14.8	16.4	16.5	18.5	15.7
ONT	13.5	13.0	14.5	14.3	13.0	13.1	12.5	12.7	12.9	12.3
MAN	13.1	14.1	17.5	15.4	14.7	11.8	14.0	13.4	15.8	12.7
SASK	14.9	14.0	15.6	17.3	14.9	15.9	17.7	17.5	14.9	13.5
ALTA	15.8	16.9	17.9	16.5	15.4	18.1	15.9	16.2	16.7	17.2
BC	16.9	16.4	17.6	18.3	16.2	14.8	14.5	15.0	14.8	13.4
YUKON **	1.9	1.8	2.4	3.2	2.7	5.0	2.2	2.9	3.6	2.3
NWT **	1.7	1.6	2.8	5.5	1.8	2.0	2.2	1.7	4.3	3.4

* Source: Statistics Canada

** Rates based on 10,000 population

Traffic Accidents

Motor Vehicle	
- Driver	245
- Passenger	137
- Unknown occupant	1
TOTAL	383
Motorcycle	31
Motor Vehicle/Train Collision	
- Driver	4
- Passenger	1
TOTAL	5
Motor Vehicle Collapsed on Victim	2
Pedestrians	
- Motor vehicle	52
- Trains	1
TOTAL	53
Bicycle/Motor Vehicle Collision	4
TOTAL TRAFFIC FATALITIES	478

Non-Traffic Accidents

A. INDUSTRIAL

Train derailment	1
Crushed between box cars	1
Hit by train	1
Roller into ditch	1
D-8 Cat roll	1
Crushed by machinery	2
Drowning	1
Hit by vehicle	1
Hit by tree	4
Crushed	2
Hit by moving machinery or parts	6
Ground cave-in	2
Explosion	3
Overcome by gases	3
Laceration	1
Electrocution	1
Fall	2
Clothing caught in machinery	1
TOTAL	34

B. FARM

Tractor roll	9
Hit by truck	1
Trapped under truck box	1
Struck by tractor bucket	1
Using blow torch near gas can	1
Touched overhead wires with irrigation pipe	1
Arm caught in saw	1
Fall from horse	1
Trench cave-in	1
Kicked by horse	1
Crushed while repairing swather	1
Struck by falling hay	1
Scarf caught in grain auger	1
TOTAL	21

C. SPORT-RELATED

All terrain vehicle		1
Drowning		39
- All terrain vehicle	1	
- Boating	16	
- Fishing	1	
- Ice fishing	2	
- Struck by lightning while canoeing, drowned	1	
- Swimming	16	
- Thrown from horse	2	
Hang gliding		1
Hiking		2
Hit by boat		1
Parachuting		2
Snowmobiling		1
Ultralight		3
Winter skiing		2
TOTAL		52

D. OTHER

Aircraft		20
Anaesthesia		1
Asphyxia/suffocation		28
Carbon monoxide (not fire-related)		9
Drownings (not sport related)		11
- Bathtub	4	
- Fall through ice	1	
- Playing in/near water	4	
- Wading across river	2	
Drug overdose		4
Electrocution		2
Falls		94
Firearms		7
Fires		55
- Burns	8	
- Carbon monoxide (fire-related)	35	
- Motor vehicle	2	
- Smoke/gases	10	
Food poisoning		1
Hanging		2
Hyperthermia		1
Hypothermia		20
Late effects of trauma		1
Steam burns		1
Struck by tree		2
Therapeutic misadventure		8
Woodworking		1
TOTAL		268
Total non-traffic accidents		375
TOTAL ACCIDENTAL DEATHS		853

ACCIDENTAL CARBON MONOXIDE POISONING

Circumstance	Total Cases
Working on car in closed garage	3
Collapsed in garage after starting car	1
Propane heater in van	2
Gas furnace leak	2
Working beside car in closed garage	1
TOTAL	9

Unclassified Deaths

Causes of Death	
Chronic and/or acute alcoholism and sequelae	98
Alcohol and drug overdose	11
Drug overdose	30
Methanol ingestion	2
Solvent inhalation	1
Fall related to intoxication	1
Aspiration of food due to intoxication	8
Drowning due to intoxication	3
Hypothermia due to intoxication	9
Downs Syndrome	1
Maternal drug misuse	1
TOTAL	165

Undetermined* Deaths

Unable to determine exact cause of death	32
Drug overdose	10
Alcohol intoxication	2
Carbon monoxide	5
Drowning	7
Firearms	1
Cut or pierce	1
Fall	1
Inhalation of toxic fumes	2
Train/pedestrian	2
Child battery	1
Other or unspecified	8
Aircrash	1
Hypothermia	1
TOTAL	74

* Undetermined whether accidental, self-inflicted, or homicide.

Sudden Infant Death Syndrome

AGE GROUP	Calgary	South Rural	Edmonton	North Rural	TOTAL
Less than 1 month	1	2	0	2	5
1 - 3 months	8	11	14	16	49
4 - 6 months	4	5	8	4	21
7 months and older	1	1	0	1	3
TOTAL	14	19	22	23	78

Sudden Infant Death Syndrome is the leading cause of death among infants from 1 week to 1 year of age. In Alberta, S.I.D.S. accounted for 78 infant deaths in 1984. The overall incidence of S.I.D.S. has been reported as 1 case per 1,000 live births. Although it can occur at any time during the first year of life, the peak incidence in Alberta is during the first three months.

S.I.D.S. STATISTICS FOR SELECTED CITIES

Location	1980	1981	1982	1983	1984
Calgary	14	22	24	15	12
Edmonton	17	25	26	26	22
Lethbridge	3	2	4	0	1
Fort McMurray	0	0	1	0	3
Red Deer	4	1	1	1	0
St. Albert	0	0	1	0	1
Medicine Hat	2	2	1	2	2
Leduc	0	0	1	0	1
Grande Prairie	0	0	1	0	2
Camrose	0	0	1	0	0

Public Inquiries

PUBLIC INQUIRIES SUMMARY

(April 1, 1984 - December 31, 1984)

Judicial Recommendations For the Prevention of Similar Deaths

Manner of Death	Given	Not Given	
Natural	2	5	
Homicide	0	1	
Suicide	4	4	
Accident	12	14	
Unclassified	1	2	
Undetermined	0	1	
TOTAL	19	27	46

TYPES OF PUBLIC INQUIRIES

A. Hospital/Institutional Related

- Natural	4
- Suicide	1
- Unclassified	1
- Undetermined	1
- Accidental	
- Anaesthetic allergy reaction	1
- Swallowed foreign object	1
- Improper drug administration	1
- Hypothermia	1
TOTAL	11

B. Motor Vehicle Related

- Military	3
- Collision	7
TOTAL	10

C. Occupational Related

- Cave-in	1
- Drowning	2
TOTAL	3

D. Police/Incarceration Related

- Suicide	4
- Natural	1
- Accidental drug overdose	1
TOTAL	6

E. Sport/Recreation Related

- All terrain vehicle	1
- Drowning, swimming pool	1
- Parachute	1
- Ultralight craft	1
TOTAL	4

F. Other

- Suicide	3
- Natural	2
- Homicide	1
- Unclassified	2
- Accidental	
- Hypothermia	1
- Asphyxia	1
- Fall	1
- Gunshot wound	1
TOTAL	12
TOTAL PUBLIC INQUIRIES	46

Responses to Judicial Recommendations

Alberta Government Departmental Responses to judicial recommendations made at Public Inquiries convened between April 1, 1984 and December 31, 1984, under the provisions of the Fatality Inquiries Act.

Case	Description	Judicial Recommendations	Response
1 Lodging of plastic and wool foreign body in larynx	Accidental. Patient of Alberta Hospital, Ponoka, who swallowed foreign body. Examination was performed outside the hospital and the Ponoka Medical Clinic indicated there was no clinical evidence of inhaling a foreign object, although nurses' notes indicate a history of swallowing objects.	1) It would appear desirable that a written history of each patient accompany the patient for an outside medical consultation, particularly where the patient is unable to communicate.	**Alberta Hospital, Ponoka** Clinical Records policies and practices now include arrangements for patient charts, in custody of staff member, to accompany patient receiving outside medical treatment.
2 Freshwater drowning	Accidental. A community league playground supervisor, employed for the summer, arranged for a special activity, namely a swimming party at a privately-owned swimming pool.	1) Any swimming activity requires at least two responsible adult supervisors, particularly when you have a mixed group of youngsters who are swimmers and non-swimmers. It is desirable that one of these supervisors have some knowledge of mouth-to-mouth resuscitation.	**Alberta Recreation and Parks** The department does not prescribe or regulate swimming activities at privately-owned swimming facilities.
3 Asphyxia, hanging	Suicide. Deceased committed suicide in "Drunk Tank" cell at the St. Albert RCMP detachment following his arrest for a drinking driving offence.	1) Exposed bars and other structural elements in cells, which could be utilized by prisoners attempting suicide, should be eliminated. 2) Cells should not have 'blind spots' wherein prisoners cannot be observed by guards and should be constructed in such a way that guards can easily hear a prisoner in distress. 3) Guards should be checked for physical disabilities which might affect their ability to perform their duties. Location of radios in the cell area should be re-considered. 4) When calls are placed for medical or para medical assistance, sufficient particulars should be given to	**Alberta Solicitor General** Correspondence forwarded to all Alberta Police departments by Director of Law Enforcement.

Case	Description	Judicial Recommendations	Response
		ensure that those who respond have the required equipment. 5) Within reasonable limitations, police should facilitate and assist in the placement of telephone calls by an accused whose ability is impaired.	
4 Hemorrhage due to lacerations of liver, spleen, kidney, and diaphragm, resulting from Three Wheel All Terrain Vehicle Accident	Accidental. Passenger riding on an ATV which flipped end-over-end. Vehicle being operated for recreational purposes by an 11-year-old child.	1) It is recommended that users of ATV follow the recommendations of manufacturers and dealers and in particular: a) Children should not operate these vehicles without adult instruction and strict supervision. b) Passengers should not be carried on these vehicles. c) Drivers should always wear helmets and suitable protection.	**Alberta Solicitor General, Motor Vehicles Division** Provisions currently exist in the Highway Traffic Act that require operators of mopeds and power cycles to wear helmets. Also, no person under the age of 16 years is permitted to carry any passenger on a scooter, moped or power bicycle. The Motor Vehicle Division has been examining the whole issue of licensing and the wearing of protective helmet on off-highway vehicles including ATV. The recommendations will be included in our overall review.
5 Asphyxia, cave in	Accidental. Deceased was employed for the purpose of installing culvert; stand pipes and road clearing on highway near Innisfail. The crew was attempting to lift the stand pipe into place. The bank fell out from under the existing road and buried deceased.	1) The circumstances of the accident which led to the death should be reviewed and the provisions of Section 32 of the Act considered.	**Alberta Occupational Health and Safety** A recommendation was made to the Attorney General that prosecution be commenced. Prosecution was commenced pursuant to the provisions of Section 32 of the Occupational Health and Safety Act.
6 Asphyxia, hanging	Suicide. Deceased committed suicide after being discharged from Alberta Hospital Edmonton about 48 hours earlier. The deceased had, in fact, advised that he would commit suicide after being discharged.	1) There may very well have been sound clinical grounds in rejecting the threat of the deceased to take his own life but I strongly recommend that in future a totally independent opinion ought to be mandatory from a properly trained person outside the institution. The very least that could have been done in this case is to have diarized the discharge file 2-3 weeks, assess his progress, and consider the appropriateness of a discharge or his remaining.	**Alberta Hospital, Edmonton** Totally independent opinion may be difficult to secure; this hospital probably has the most expertise of any organization in Alberta to deal with difficult psychiatric cases. In relation to diarizing the file in relation to discharge mechanism, this is in fact done.

Case	Description	Judicial Recommendations	Response
7 Cardiac Arrest as a consequence of hyper-kalemia due to the too-rapid administration of potassium chloride intravenous	Accidental. Deceased underwent elective surgery at the Royal Alexandra Hospital. Blood taken post-operatively revealed a low level of potassium. A second year medical resident discussed the matter with a second year medical student intern and decided it would be appropriate to administer 40 mg. of potassium chloride. He did not commit this to writing and did not direct the method of administration.	1) All personnel assigned to the ICU should be thoroughly instructed and briefed on terminology and procedures before assuming any duties whatsoever. The Director of the ICU be responsible to ensure to his satisfaction that every person employed in ICU has been totally instructed and understands, particularly in terms of drug administration. 2) A nurse about to administer medication to check the dosage with a second nurse on duty. Should be expanded to require that the second nurse compare the dosage produced with the actual written order of the physician and the actual method of administration of the medication. 3) Use of any terminology which could be confusing be totally avoided in ICU and the taking of orders from anyone other than a physician should be absolutely and unconditionally forbidden.	**Alberta Hospitals and Medical Care** The findings and recommendations have been referred to the hospital board concerned for appropriate action. It is noted that the Royal Alexandra Hospital has already taken certain steps to improve procedures and communication in the ICU.
8a Massive skull fracture 8b Aspiration of gastric contents 8c Cervical Fracture C4/C5 Motor Vehicle Accident	Accidental. Passengers in the back of a military troop carrier. The driver lost control. The vehicle fishtailed and rolled. Twenty-six soldiers were thrown to the ground.	1) A great many military regulations were broken: a) The driver not properly licensed. b) The vehicles did not travel in a proper convoy. c) The vehicle had not been properly inspected before it left Shaw Lake. d) No first aid kit in the vehicle. I recommend that the military officials ensure that their regulations are followed. 2) The particular corner on the Shaw Lake Road should be marked with a special sign(s) as it appears to present a greater navigational problem than all of the other corners on that road.	**Alberta Transportation** The recommendation (#2) is being forwarded to this department's Regional Director at St. Paul for the necessary attention. A curve sign has been installed at both sides of the accident site. Caution tabs have been installed.

Case	Description	Judicial Recommendations	Response
9a Drowning 9b Drowning Power Boat Accident	Accidental. Both decedents were tagging fish in a canal using a small jet powered boat. The boat came too close to the weir upstream and was caught in the turbulence at the base of the weir.	1) Intensive and graphic safety training for all employees working near waterfalls and weir areas to emphasize the magnitude of the hazard involved. 2) Public education through Health and Safety channels to point out the hazards of swimming and boating near waterfalls and weirs. 3) Vivid signs, well placed, to warn public of attendant dangers at waterfalls and weirs.	**Alberta Energy and Natural Resources** Fish and Wildlife Division has acted upon the first recommendation. This type of safety training has been incorporated as an integral part of the Division's boat operation training courses. **Alberta Environment** Department officials have emphasized the dangers of these types of structures to all employees who work near them. The department, through its Weir Safety Committee, has been communicating to the public through newspaper ads, brochures, posters, displays, and news releases, in an ongoing effort to educate water users of the dangers of these structures. Signs have been placed upstream and downstream of all structures along the canal in question. **Alberta Occupational Health and Safety** An order was written to Alberta Energy and Natural Resources requesting the submission of updated training programs and safe work procedures. The report has been submitted.
10 Asphyxia, hanging	Suicide. Deceased was a permanent ward of the government since 1977. Had attempted suicide on previous occasions.	1) That the judges, crown counsel, and defence lawyers, in all courts dealing with native child welfare issues, examine their educational programs to ensure they contain sufficient native cultural content. 2) Child care workers be required to participate in a course(s) relating to native culture, suicide, and depression. 3) In cooperation with Foster Parent Associations, the Department institute mandatory programs of education for all foster parents	**Alberta Attorney General** The Department has undertaken a cross-cultural awareness program since 1981. To date 331 participants have completed seminars. Solicitors, Barristers, Crown Prosecutors and members of the Judiciary have taken seminars. The program is continuing to be revised and updated. **Alberta Native Affairs** Appointment of a working committee on Native Child Welfare. The Government has taken an active role in assisting native people to take responsibility for the delivery of services for

Case	Description	Judicial Recommendations	Response
		with content on depression and suicide and for all non-native foster parents with native children material on native cultural issues. 4) Each native ward placed in a non-native home be, at the appropriate age, exposed to training in his or her own heritage and traditions. 5) A more active role be taken by the Department than is presently provided by the supported independent living program, to assist all wards in the transition from wardship to adult status. 6) The Department reinforce the responsibility of child care workers to make the contact required by the child welfare programs manual. 7) Consideration be given to the recruitment and training of native counsellors to assist child care workers in visiting native children in care. 8) Arrangements to be made to obtain lists of accredited psychologists from the Psychologists Association of Alberta, so that social workers making referrals for psychological assessments may be assured of the qualifications of the psychologist chosen. 9) Special efforts be made by social workers to work with the parents and foster parents of enuretic children with a view of not using enurism as an excuse for placement change. 10) Courses for the Bachelor of Social Work Degree have included within them mandatory studies of native issues suicide and depression. 11) The Government seek to establish new multi-disciplinary in-patient (or residential) psychiatric clinics for children. 12) The Government seek to	family and children in their community. Recommendations related to child welfare from seminars, are currently under consideration by the working committee. **Alberta Education** Working with various school boards and Native groups to develop student learning resources for and about Native people for use by all students in provincial schools. **Alberta Social Services and Community Health** Training program for child welfare workers and child care counsellors have been adjusted to include content in native culture, suicide and depression. Mandatory orientation sessions for new foster parents are provided and are supplemented by non-mandatory in-service training sessions in regions. The Child Welfare Act establishes the legal requirements to respect and maintain a child's cultural heritage. It also includes certain provisions enacted to ensure that the rights of Indian families and children are protected. Departmental policy requires that when a native child is placed in a non-Native home, the care-givers must be willing and able to ensure the child's cultural heritage is maintained. Native Child Welfare Practice Guidelines have been developed and provided to child welfare staff and care-givers. Foster parent orientation and training promote native cultural awareness. Ongoing initiatives are promoting the provision of child welfare services by Native communities. A child welfare pilot project is underway regarding supported

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		immediately establish additional hospital beds for children and young people in need of psychiatric care. 13) All patients transferring from one hospital to another be accompanied by a complete written report from the referring hospital under the authority of the original doctor. 14) Each medium which is able to do so accept the challenge to increase its coverage of native issues, and again where possible adopt a conscious policy of public education on native matters. 15) That native organizations with the cooperation of the Department of Child Welfare provide more assistance to native people prior to the first court appearance in native child care proceedings. This would include where possible doing their own preliminary investigations. 16) That native people develop content for and offer workshops for professionals involved in native child care service delivery. 17) That native people provide educational material for dissemination to individuals, organizations, and institutions which may be interested in it. 18) That native organizations actively recruit native people to both assist existing social workers and to become full time employees in the delivery of child care services. 19) That native people systematically and actively recruit native foster homes. 20) That native people organize and establish native group homes. 21) That native people work with the Department of Social Services in providing native heritage programs to wards of the government.	independent living for youths leaving the child welfare system. Extensive research on transitional planning to prepare youth for independence is completed and recommendations for new service initiatives for this age group are under review. Service delivery standards and monitoring systems in place are reinforcing the frequency of contact by child welfare workers with children in care. A Native Apprenticeship Program was announced by the Minister. A Native Bursary Program has been approved to enable 10 native persons to receive training assistance in post-secondary education in social services. In the last fiscal year, the department hired nearly 50 Native employees. A list of accredited psychologists was sent to each district office. Within the context of working with children, families and foster parents resource tools that address clinical needs and case management procedures are being developed to assist both caseworkers and supervisors. **Alberta Hospitals and Medical Care** Inter-Departmental Committee is studying needs for these services in Alberta. As well, need for Psychiatric/Out-patient services for children and adolescents is being actively reviewed by several government departments. A program to provide incentives for physicians to work in underserviced areas has been implemented by the Department of Hospitals and Medical Care. This program may also encourage psychiatrists to practice in areas outside of urban centres in the province.

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		22) That school boards across the Province include in the curriculum of each student full material on native heritage and values.	It is accepted practice that when patients are transferred from one facility to another, appropriate medical documentation accompanies them. This matter has been reviewed with the Mayerthorpe Hospital.
11 Bronchial Asthma	Natural. Deceased suffered an asthmatic attack. Daughter drove her towards the Misericordia Hospital, stopping at a Medicentre on the way. The Medicentre refused to help, but told her to go to the hospital which was over one kilometre away.	1) Upgraded training for registered nursing assistants might be of some assistance.	**Alberta Advanced Education** The Alberta Association of Registered Nursing now offers a continuing education course entitled Legal Aspects for Registered Nursing Assistants in the Nursing Profession. **Alberta Hospitals and Medical Care** The College of Physicians and Surgeons and the Administration of the Medicentre have taken appropriate action.
12 Methanol Poisoning	Undetermined. Deceased drank a large amount of methyl alcohol. Was admitted to Edmonton General Hospital. Diagnosis was difficult because the deceased did not exhibit any obvious abnormalities, nor did he provide helpful or consistent information.	1) Greater emphasis should be placed on the recognition and treatment of this condition. More prominent warnings should be placed upon the identification, labelling and advertising of products containing wood alcohol. 2) Emergency/Admitting departments should be notified immediately upon a patient's transfer to another hospital which information should be readily available to concerned relatives and friends of the patient involved.	**Alberta Hospitals and Medical Care** Hospital staff in emergency and admitting departments ordinarily inform friends and relatives of patients.
13 Bilateral Pneumothorax Hyperthermia	Accidental. Deceased was kept in a radiant warmer under a plastic thermal blanket. Baby was found to be greatly over-heated. The probe had slipped off, but the alarm had not sounded, because the probe had adhered to one of the plastic bubbles in the blanket.	1) Avoid routine use of thermal blankets or heat shields with radiant warmers. Plastic heat shields placed well above the infant may cause some changes in radiant warmer performance, but are less likely to come into direct contact with the sensor's temperature-sensing surface. 2) If it is necessary to use a plastic thermal blanket or heat shield, check temperature, radiant warmer function, and	**Alberta Hospitals and Medical Care** The findings and recommendations put forth by the judge have come to the attention of Dr. Dasgupta of the Health Protection Branch, Health and Welfare, Canada. Subsequently, an extensive circulation of a medical devices alert outlining hazards and proper use of all thermal coverings was distributed to all Hospital Administrators in Canada.

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		sensor placement at least every 15 minutes. 3) If plastic thermal blankets or heat shields must be used, consider using a separate temperature monitor with properly set high-low temperature alarm functions to monitor infant skin and core temperature. 4) The nursing staff be made aware of these recommendations, procedures to be used, problems that may be encountered and operating anomalies that are likely to occur.	